A. INTRODUCTION

Section II of this handbook describes basic coverage and limitations on vision procedures in the Wisconsin Medical Assistance Program (WMAP). Providers must familiarize themselves with this section in order to ensure that only covered services are rendered in compliance with all appropriate guidelines. Appendix 1 of this handbook contains a complete listing of all covered services.

Optometrists may be reimbursed for all procedures listed except that only TPA-certified optometrists may be reimbursed for procedures requiring TPA certification. Opticians may be reimbursed only for procedures pertaining to the dispensing and repair of eyeglasses.

Ophthalmologists may be reimbursed by the WMAP for all procedures listed in Appendix 1 of this handbook as well as WMAP-covered services identified in the Physician's Current Procedural Terminology (CPT). Ophthalmologists are referred to the Physician Handbook, Part K, for additional information on covered services.

B. STATE PURCHASE EYEGLASS CONTRACT (SPEC)

Under the State Purchase Eyeglass Contract (SPEC), all vision care providers certified in the WMAP must order all WMAP-covered eyeglasses and component parts directly from the provider contracted with the Department of Health and Social Services (DHSS) to supply those services.

Effective with orders placed on and after April 1, 1995, Precision Optics is the SPEC contractor. The address for the SPEC contractor is:

The Omega Group
Precision Optics, Incorporated
Box 1228, 6925 Saukview Drive
St. Cloud, MN 56302

Procedures for Ordering Materials

Vision care providers must order materials from the SPEC contractor on an order form supplied by the SPEC contractor. For SPEC billing information, refer to Section IV-E of this handbook.

Properly ordered materials, except in unforeseen or unusual circumstances, are expected to be shipped to providers by the SPEC contractor within six working days of receipt of the order. Providers should allow for mailing time for orders and materials when calculating an expected delivery date. If an order is not received within 14 days, providers should telephone the SPEC contractor. To expedite processing of orders, please type or clearly print all orders accurately and completely. Illegible orders will require additional processing time to clarify or return.

If within 30 days of delivery any material is found by the dispensing provider to be unsatisfactory due to the SPEC contractor's error, defective workmanship, or materials, the provider should return the materials and order form to the contractor. The SPEC contractor is required to adjust, correct, or replace the materials at the SPEC contractor's expense. The SPEC contractor is not liable for the cost of replacement orders required due to errors made by the prescribing or dispensing provider, nor for defective materials not reported within 30 days of delivery.

SPEC Lenses

The SPEC includes glass, plastic, and polycarbonate lenses for single vision, multifocal, and cataract lenses. Contracted lenses must conform to the American National Standards Institute (ANSI) recommendation for prescription of ophthalmic lenses, ANSI Z80.1 - 1979, and the Food and Drug Administration (FDA) requirements for impact resistant lenses. Providers should refer to Appendix 2 of this handbook for a list of lenses covered under the SPEC.

B. STATE PURCHASE EYEGLASS CONTRACT (SPEC) (continued)

SPEC Frames

The SPEC includes frames which meet ANSI Z80.5 - 1979 Standards. (Refer to Appendix 3 of this handbook for a list of SPEC-covered frames).

WMAP vision care providers must purchase a sample kit of SPEC frames. Sample kits are available from the contractor. Providers will not be reimbursed for materials included in sample kits. A sample kit can be ordered by writing to the SPEC contractor.

Ordering Partial Appliances

If a recipient requires new lenses only, the dispensing provider must, whenever possible, send the recipient's existing frames to the SPEC contractor with the lens order. Orders received by the contractor as "frame enclosed" must include:

- the actual frame or a machine-made pattern (not a hand tracing) with the order, if the frame enclosed is a new frame; or
- the actual frame, if the frame enclosed is a used frame. Hand tracings or drawings are not acceptable.

Orders without the frame enclosed, or without a pattern for a new frame, may be returned to the ordering provider within three working days of receipt of the order with a written explanation as to why the order was not processed.

The lenses are then mounted in the recipient's frame. If, in the opinion of the SPEC contractor, the lenses cannot be mounted without damage to the frames, the SPEC contractor may either return the frames with the unmounted lenses to the provider with a written explanation why the lenses were not mounted; or contact the provider by telephone so the provider may order a complete appliance from the SPEC contractor.

If a recipient has a metal frame, the frame must accompany the order for lenses.

If the recipient requires a new frame only, and the recipient's lenses do not fit a SPEC frame, a complete appliance must be ordered from the SPEC contractor.

Non-Contracted Materials/Out-of-State Providers/Out-of-State Foster Children

Prior authorization is required for all non-contracted vision items and for eyeglasses, frames, lenses, and components billed for out-of-state foster children and out-of-state providers. Please refer to Section III of this handbook for prior authorization requirements and to Section IV for billing instructions.

C. EVALUATION AND DIAGNOSTIC SERVICES

Evaluation and Management Services

Evaluation and Management, New Patient

The WMAP defines "new patient" as a patient who is new to the provider and whose medical and administrative records need to be established. The WMAP interprets this to be a new patient to either the physician or clinic. The WMAP allows one new patient procedure per recipient, per performing or billing provider, per lifetime.

Evaluation and Management, Visits

Only one office visit is allowed per date of service for a new or established patient, per performing provider.

C. EVALUATION AND DIAGNOSTIC SERVICES (continued)

Ophthalmological Examinations
A refraction is not separately reimbursable with an ophthalmological examination as this procedure is included in the reimbursement for the examination. Refer to Section IV-B of this handbook for instructions on billing for refractions for dual entitlees.

A comprehensive ophthalmological examination for an established patient may be reimbursed once per recipient, per performing provider, per 12-month period without prior authorization. Additional comprehensive exams, if medically necessary, may be reimbursed if they have been prior authorized. (Refer to Section III of this handbook for prior authorization requirements.)

Low Vision Eye Examination
The WMAP covers one low vision examination per recipient per year. Prior authorization is required for low vision examinations.

Supplemental Tests
Supplemental tests are included in the reimbursement rate set for comprehensive or low vision examinations and are not reimbursed separately on the same date of service as a comprehensive examination or low vision examination. Refer to Appendix 1 of this handbook for information on which tests are not separately reimbursable.

D. DISPENSING AND REPAIR SERVICES

Dispensing Fees
The WMAP covers dispensing fees for furnishing contracted materials to recipients. The dispensing fee includes selecting, ordering, and dispensing contracted materials. Dispensing fees associated with non-SPEC materials are not covered by the WMAP unless the non-SPEC materials and dispensing fee have been prior authorized by the WMAP. All dispensing fees include routine follow-up and post-prescription visits for minor adjustments. The date of service used for billing purposes is the date of order of the eyeglasses. Only one dispensing fee is allowed per date of service.

Dispensing Complete SPEC Appliances
This procedure is covered when both a SPEC frame and SPEC lenses have been ordered (unifocal, bifocal, or trifocal). Only one pair and one replacement from the same prescription per 12-month period are covered unless prior authorization is obtained for additional services. (Refer to Section III of this handbook for prior authorization requirements.)

Dispensing SPEC Frames
This procedure is not covered when billed on the same date of service as dispensing a complete appliance, temple replacement, or lens replacement.

Dispensing SPEC Temple or Temples
This procedure is not covered when billed on the same date of service as dispensing a complete appliance or frame replacement.

Dispensing SPEC Lens or Lenses
This procedure is not covered when a SPEC lens(es) has been ordered (either unifocal or multifocal), on the same date of service as dispensing a complete appliance or frame replacement.

Dispensing a Complete Appliance or Lens(es) with a Changed Prescription
Providers may be reimbursed by the WMAP for dispensing one additional complete appliance or lens(es) without prior authorization when there is a documented change in the lens prescription of more than +/-.50 diopter in the spherical or cylinder power and a cylinder axis shift of greater than 10 degrees.

D. DISPENSING AND REPAIR SERVICES (continued)

Repair Service

This procedure is covered for minor repairs (e.g., new hinge, rivet, solder). Repair services beyond the 30-day warranty period are not a part of the SPEC and are not required to be ordered from the SPEC contractor. Repair services may be ordered through the lab of the ordering provider's choice, if not performed in the provider's office. Routine follow-up and post-prescription visits (for minor adjustments) are considered part of the initial dispensing fee and are not covered as repair services. However, an order that is unacceptable due to defects in materials, workmanship, or due to a processing error, must be returned to the SPEC contractor within 30 days of delivery for repair.

Date of Service

The date of service for billing the dispensing of eyeglass frames or lenses is the date the vision provider orders the materials, not the date the order was received by the SPEC contractor, nor the date the service obtained prior authorization, if required, nor the date the recipient obtains the materials. When ordering replacement materials from an existing prescription, the date of service is the date the replacement is ordered. Orders may not be backdated prior to the date the recipient is seen by the dispensing provider. Vision providers are responsible for verifying that the recipient is eligible on the date of service.

E. COVERED VERSUS NONCOVERED VISION MATERIALS

The WMAP reimburses vision providers only for covered materials listed in this handbook, when prior authorization and other requirements are met. A provider may provide a service which includes a noncovered portion. The provider may bill the recipient directly for the noncovered portion of the service only if the covered and noncovered portions of the service are distinctly separate and the recipient has been notified in advance and has agreed to pay separately for the noncovered portion. For example, a provider may order covered eyeglasses through the SPEC for a recipient, and may charge the recipient for the noncovered anti-glare coating or fashion tint that the recipient requests. This is allowable since the anti-glare coating or fashion tint may be added later as a separate procedure.

A provider may not, however, seek reimbursement from the WMAP for a noncovered service by charging the WMAP for a covered service which was not provided, and applying the reimbursement toward a noncovered service. For example, if a recipient chooses to receive photogrey lenses which have not been prior authorized, the provider may not bill the WMAP for lenses of any type and bill the recipient for the difference between the WMAP reimbursed amount and the actual cost of the service. In this instance, the entire lens is considered noncovered by the WMAP, because photogrey is an integral part of the lens and cannot be provided as a separate service.

Refer to Section IV of Part A of the WMAP Provider Handbook for information on recipient requests for noncovered services and provider acceptance of payment.

F. PRESCRIPTIONS

Requirements of Prescriptions for Drugs

Ophthalmologists practicing within their scope of practice may prescribe drugs for Medical Assistance recipients. Optometrists practicing within their scope of practice may prescribe drugs for Medical Assistance recipients if they hold a Therapeutic Pharmaceutical Agents (TPA) certificate. Before using or prescribing any Schedule II, III, IV, or V pharmaceutical agents, the provider must also obtain a Drug Enforcement Administration (DEA) certification of registration. The WMAP does not reimburse providers separately for any charges associated with writing prescriptions.

F. PRESCRIPTIONS
(continued)

Prescription Requirements

Except as otherwise noted in federal or state law, a prescription must be in writing or given orally and later reduced to writing and must include the following information:

- name of drug or service prescribed
- directions for use of the prescribed drug or item
- prescriber's name and address
- recipient's name and address
- date of the order
- prescriber's signature

E. **PRESCRIPTIONS** (continued)

Prescriptions for any Schedule II, III, IV, or V pharmaceutical agents must also contain the Drug Enforcement Agency (DEA) number of the prescriber.

For hospital and nursing home recipients, orders must be entered into the medical and nursing charts and must include the information listed above. Services ordered by prescription must be provided within one year of the date of the prescription.

"Brand Medically Necessary" Requirements

In order for a pharmacy to be reimbursed for a drug at a rate higher than that allowed for a generic equivalent, the prescribing provider must certify that a brand name drug is medically necessary by using the phrase "BRAND MEDICALLY NECESSARY" or "MEDICALLY NECESSARY."

This certification must be in the prescribing practitioner's own handwriting directly on the prescription order or on a separate authorization which is attached to the original prescription. Pharmacy orders must have this documentation prior to submitting claims to the WMAP. Prescriptions which indicate "No Substitutes" or "N.S." are not covered by the WMAP, and claims for these services are denied. The prescriber must also document in the recipient's medical record the reason why the brand drug is medically necessary.

Typed certification, signature stamps, or certification handwritten by someone other than the prescriber does not satisfy this requirement. "Blanket" authorization for an individual recipient, drug, or prescriber is not acceptable documentation. A letter of certification is acceptable as long as the notation is handwritten and is for specified drugs for an individual patient. While it is the pharmacy's responsibility to have this written documentation, it is the prescriber's responsibility to provide the pharmacy with the required documentation.

Nursing Home Orders

Prescriber certification that the brand is medically necessary must be made on each prescription order written for nursing home residents. This certification is good only for the length of time that the order is valid. Updated written certification is required for each new prescription order written.

Drug Rebate System

The drug rebate system is the result of the federal Omnibus Budget Reconciliation Act of 1990. Under the drug rebate system, drug manufacturers that choose to participate in state Medical Assistance programs are required to sign rebate agreements with the federal Health Care Financing Administration (HCFA). Participation in the Medical Assistance program is voluntary on the part of the drug manufacturers. Rebate agreements are valid for one year. At the end of one year, manufacturers may choose whether or not to continue participation in the rebate program. Non-participating manufacturers have the option each quarter of signing a rebate agreement which will be effective the following quarter.

Manufacturers that have signed rebate agreements have their prescription drugs covered by the WMAP if the drugs meet WMAP guidelines. For manufacturers that did not sign a rebate agreement, the WMAP does not cover drugs produced by the manufacturer, except as noted in Appendix 12 in this handbook. The prescriber may wish to contact a local WMAP-certified pharmacy to confirm the WMAP coverage status of a particular drug or product.

E PRESCRIPTIONS (continued)

Appendix 12 of this handbook is a list of the types of drugs that are covered by the WMAP, including those which require prior authorization. Appendix 13 of this handbook lists noncovered drugs, including drugs sold by manufacturers that did not sign rebate agreements.

Documentation for Drugs Manufactured by Companies That Have Not Signed a Rebate Agreement

The WMAP recognizes that there are a few cases where it is medically necessary to provide a drug that is produced by a manufacturer that did not sign a rebate agreement. These drugs may be provided to the recipient when the pharmacy completes a prior authorization request.

The prescriber must provide the following documentation to the pharmacy in the above instance:

- A statement indicating that no other drug produced by a manufacturer that signed a rebate agreement is medically appropriate for the recipient.
- A statement indicating that WMAP coverage of the drug is cost effective for the WMAP.

A recipient request for a particular drug is not considered adequate justification for granting approval without the prescriber demonstrating medical necessity.

G NONCOVERED SERVICES

The following services and items are not covered under the WMAP:

1. Services and items requiring prior authorization for which authorization has been either denied or not requested. If a provider fails to request prior authorization for a service which requires prior authorization, the recipient may not be billed.
2. Dispensing services related to noncovered items.
3. Eyeglass cases.
4. Spare eyeglasses.
5. Tinted lenses for non-medical reasons.
6. Anti-reflection coating.
7. Services or items provided principally for cosmetic reasons, including gradient focus or progressive bifocals, fashion or cosmetic tints, engraved lenses, and anti-scratch coating.
8. Charges for telephone calls.
9. Charges for missed appointments.
10. Consultations between or among providers.